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MINUTES OF THE MEETING OF THE SECRETARY OF STATE FOR TRANSPORT'S HONORARY MEDICAL ADVISORY PANEL ON DRIVING AND DISORDERS OF THE CARDIOVASCULAR SYSTEM

THURSDAY, 18 SEPTEMBER 2014

Present:

Dr M J Griffith	Chairman
Dr A Kelion	
Dr L Freeman	
Mr A Goodwin	
Dr R Henderson	
Dr D Northridge	
Dr D Fraser	

Lay Members

Mr B Nimick
Mr D Simpson

Ex-officio:

Dr S Mitchell	Civil Aviation Authority
Dr E Keelan	National Programme Office for Traffic Medicine, Dublin
Dr S Parry	Clinical Senior Lecturer/Royal Victoria Infirmary
Dr W Parry	Senior Medical Adviser, DVLA
Dr A Kumar	Panel Secretary/Medical Adviser, DVLA
Dr K Davies	Medical Adviser, DVLA
Dr J Morgan	Medical Adviser, DVLA
Mrs J Leach	Medical Licensing Policy, DVLA

1. Apologies for absence

The Chairman opened the meeting with introductions.

Apologies were received from Professor C Garratt and Mr M Gannon.

2. Minutes of the meeting of 20 March – Matters arising

(i) Item 4 (reference to the EU Cardiology Working Group proposed legal text Section 9.4.2): Thoracic and abdominal aortic aneurysm

Group 2 licence standards: "*Driving licences will not be issued to, or renewed for, applicants or drivers if the maximum aortic diameter exceeds 5.5 cm".*

It was agreed by Panel (March 2014) that the phrase "*unless appropriately treated*" needs to be added to the above existing sentence. Hence, it should read as follows "*driving licences will not be issued to, or renewed for, applicants or drivers if the maximum aortic diameter exceeds 5.5 cm, unless appropriately treated*". Panel secretary sought clarification that this would imply that if treated appropriately then a Group 2 licence would be allowed despite diameter greater than 5.5 cm. A discussion ensued on this topic. The implication of the phrase "*appropriately treated*" was discussed as to whether this would include appropriate medical treatment as well, that is control of blood pressure**,** or would strictly mean surgical/endovascular treatment of the aneurysm. Panel agreed that for Group 2 licensing purposes**,** driving licences shall not be issued to drivers or applicants if the maximum aortic diameter is greater than 5.5 cm unless appropriately treated by surgery or endovascular treatment. If following appropriate treatment aortic diameter is greater than 5.5cm, these cases need to be dealt with on an individual basis (with referral to panel member if needed) and if licensed would require regular medical follow-up and a review licence.

(ii) Item 4 (reference to EU proposed legal text Section 9.6.1: Valvular heart disease:

Group 2 licence standards: *"Driving licences shall not be issued to, or renewed for, applicants or drivers with mitral stenosis and severe pulmonary hypertension*

and for applicants or drivers with severe echocardiographic aortic stenosis or aortic stenosis causing syncope".

Current UK standards disqualify **symptomatic aortic stenosis** from Group 1 and Group 2 driving but in case of **asymptomatic severe aortic stenosis**, Group 2 licence standard requires the individual to undergo an exercise tolerance test before a Group 2 licence is issued on an annual basis. With the European standards, a Group 2 licence would be refused/revoked in all cases of severe echocardiographic aortic stenosis irrespective of symptomatology. This issue was discussed at length at the March 2014 meeting and Panel had agreed that there would be a very small group of individuals with asymptomatic severe aortic stenosis who would be able to meet the current DVLA exercise tolerance test requirement and be issued with a Group 2 licence. Hence, the European Union proposed standards for severe aortic stenosis do not seem unreasonable.

Dr Freeman and Dr Henderson mentioned that this small group of individuals may include patients with congenital or acquired aortic valve disease who have severe echocardiographic aortic stenosis but might be truly asymptomatic and be able to fulfil the current DVLA exercise tolerance test requirements without development of symptoms or ECG changes. In their opinion these individuals are unlikely to have greater than 2% annual risk of a sudden disabling event if they have demonstrated that they can satisfactorily complete 9 minutes of a Bruce protocol exercise tolerance test without development of any symptoms and/or ECG changes. Hence, this group of individuals would be disadvantaged if DVLA follows the proposed EU standards that a Group 2 licence shall not be issued to individuals with severe echocardiographic aortic stenosis.

All member States have to follow the minimum European driving licence standards. If the current UK guidelines are to be followed in cases of severe aortic stenosis, they would be more lenient than the EU minimum standards and this would not be acceptable. Hence it is important for UK panel to make the EU working group aware of this issue. Dr Freeman has agreed to provide a form of words to support the

current UK guidelines for severe aortic stenosis, this to be forwarded to the EU Working Group for consideration (preferably by the end of September as the next Driving Licence Committee meeting is on 24 October as advised by DVLA Medical Policy Group).

3. Minutes of the Chairmen's meeting of 19 June2014

Dr Kelion attended the Panel Chairmen's meeting in June 2014 on behalf of the Chairman, and updated the Panel chairmen on the main developments in the Cardiovascular Panel.

4. Syncope

Panel welcomed Dr Steve Parry who gave an excellent and informative presentation on 'syncope' with particular reference to driving and reasons why syncope should have a place under the cardiovascular section of the 'At a Glance Guide to the Current Medical Standards of Fitness to Drive'. Panel agreed that a joint meeting with the Neurology Panel is needed before any revision of the syncope licensing standard is undertaken.

5. Ventricular tachycardia: Group 1 and Group 2 licence standards

Currently, DVLA does not have separate licence standards for ventricular tachycardia and cases are processed based on the standards for arrhythmia.

Panel agreed that in addition to the current arrhythmia standards, cases of ventricular tachycardia need regular medical follow-up unless treated definitively by ablation. There is no need to have separate licensing standards for ventricular tachycardia in the 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' but the need for regular medical follow-up for ventricular tachycardia should be reflected in the section for arrhythmia standards.

6. Stress echocardiography and myocardial perfusion scan: Group 2 licence standards

The current Group 2 licence standards for stress echo and myocardial perfusion scan do not state whether the occurrence of **symptoms** (eg. chest pain, dizziness etc) or **ECG changes** has to be taken into account for a licensing decision or not.

Panel agreed that if exercise is the stressor agent used for either the myocardial perfusion scan or stress echo, then any relevant symptoms +/- ECG changes during the MPS/stress echo need to be interpreted similar to the exercise tolerance test criteria for myocardial ischaemia (as quoted in the 'At a Glance Guide to the Current Medical Standards of Fitness to Drive'). If a pharmacological stressor is used (Adenosine, Dobutamine etc), then symptoms +/- ECG changes do not need to be interpreted as indicative of myocardial ischaemia unless suggested by the reporting cardiologist.

Pharmacological agents can cause symptoms of chest pain +/- dizziness as part of their pharmacological effect even in the absence of reversible myocardial ischaemia.

7. Progress of the European Union Cardiovascular Working Group Report

(i) The wording regarding stable angina – Group 1 licence (9.3.2 in the legal text of the proposed EU standards) :

Following correspondence with the Working Group the following wording has been agreed – "*Driving licence will not be issued to, or renewed for, applicants or drivers if symptomatic of angina at rest or whilst driving. Driving may be allowed to resume after treatment if it is proven that symptoms do not recur at rest or whilst driving*".

(ii) ICD, long QT and Brugada syndrome

The Panel Secretary and Chairman have been in correspondence with the European Working Group on the above issues. The Panel Chairman sent a formal document

to the EU Working Group, representing UK Cardiovascular Panel's views on this topic. A response from the Working Group has been received with the proposed changes to the wording relating to long QT syndrome and Brugada syndrome. The Panel Secretary circulated a copy of this amended version and a copy of the formal correspondence to all Panel members present at the meeting.

The Panel Chairman will send a formal response to the Working Group enclosing his comments with regards to the latest amended version for the long QT syndrome and Brugada syndrome before the next Driving Licence Committee meeting.

The next Driving Licence Committee meeting is on 24 October 2014 as advised by the DVLA Medical Policy Group representative.

The proposed EU legal draft with the complete Working Group report was enclosed with the March 2014 Panel agenda bundle.

The Panel Chairman requested that a copy of this report be re-circulated to all Panel members via e-mail for a final review before any comments could be sent to the Group.

Discussion points:

For the long QT syndrome standards, Panel still think the phrase "*QTc has ever been more than 500 ms*" is too restrictive and a more appropriate wording would be "*if QTc is more than 500 ms*" followed by "*driving may resume if according to specialist's opinion the yearly risk of sudden incapacitation event is below 22%".*

QT duration in long QT syndrome can vary with time, and in these individuals a QTc of more than 500 ms is a risk marker for Torsades de Pointes and sudden death. However, Panel do not think that just because QTc has **ever** been greater than 500 ms that the risk is high enough to preclude driving (Group 1 or Group 2) and permanent restriction of Group 2 is too strict.

It was clarified by the Chairman that these standards apply to cases of **long QT syndrome** and ***not*** cases where an individual has had long QT duration due to any reversible cause. The criteria to define the **long QT syndrome** have been detailed in the Working Group report.

Panel members queried that once the European Union Working Group guidelines are transcribed into European law, will there be any scope of cases to be considered beyond the European Union standards on exceptional grounds. Mrs Leach confirmed that the minimum EU standards need to be met in all cases and cases cannot be considered below the minimum EU standards. As discussed before, higher standards can be observed by the UK with supporting medical evidence. It was mentioned that DVLA has faced operational problems with the implementation of the new European standards in other areas. Hence the opportunity to have early input from both Panel Secretary and from the Cardiovascular Panel has been crucial and will hopefully help avoid any significant future problems when implementing into domestic law.

Panel also queried whether**,** once the standards are transcribed in law, will there be any mechanism for regular review of the European Union driving laws in relation to medical standards. Mrs Leach explained that under the 'European Refit Programme', a member State can request the Driving Licence Committee for revision/review of a medical standard if they feel the need for it or if they have any concern regarding the present laws. Additionally, the Driving Licence Committee undertakes regular review at 5 years, and the medical policy representative also explained that once the EU laws are finalised and voted for by the UK, DVLA will need to engage in dialogue with the Department of Transport legal expert with medical input (Drivers Medical Group, DVLA) to adopt the European Union laws into domestic UK legislation.

8. Cases for discussion

Four cases were discussed and appropriate advice given (M16904996, M24157776, M1682638, M23397746).

Panel agreed that the advice for cases where there has been a conflict between the results of functional test and the recent angiogram remains the same, that is, individual assessment and careful interpretation of the submitted angiogram report if available.

If there has been a failed functional test, and a recent angiogram is completely normal, it is reasonable to accept this angiogram report before issuing a Group 2 licence, but if the angiogram is not completely normal and the positive functional test being referred to as false positive, before issuing a Group 2 licence this needs careful interpretation with referral to a Panel member if any doubt/concerns.

There may be a need for re-phrasing of the angiography section in the Appendix of 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' to reflect the severity of disease in epicardial arteries as demonstrated on the coronary angiogram. This may need further discussion at a future meeting.

9. Any other business

Mrs Leach advised Panel that currently DVLA is looking at extended period licensing for certain medical conditions and asked if there are any relevant cardiovascular areas where extended licensing could be considered. The Panel Chairman advised that most of the cardiovascular conditions are progressive in nature and hence at present he does not see any relevant areas to make any changes.

10. Date and time of next meeting

The proposed date for the Spring 2015 meeting is 19 March 2015.

DR A KUMAR MBBS MRCGP
Panel Secretary

24 September 2014